CARE HOME SERVICE SPECIFICATION

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Contract for Enhanced Service
1 August 2025 - 31 March 2030

Contents

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1 INTRODUCTION

This Service Specification along with the Contract Details forms the Local Enhanced Service (LES) for a Care Home Enhanced Service.

This service Specification works towards meeting the Scottish Government priorities and NHSH Annual Delivery Plan (ADP): Outcome 3, Stay well; Outcome 4, Anchor well; Outcome 9, Care well; Outcome14, Age well; and Outcome 15, End well.

2 CLINICAL SPECIFICATIONS

Purpose

People living in care homes usually have several long-term conditions and are almost universally living with frailty.

This LES recognises the need to understand, assess and manage this complexity with the person at the centre of it.

There is also a recognition that a multi-disciplinary approach is needed to deliver the service aims without over medicalising the care of the person in their own home.

Service Aims

a) To improve continuity of care for each resident through regular, planned reviews by a multi-disciplinary, skilled workforce.
b) To reliably and consistently record frailty for each resident using the Clinical Frailty Scale (CFS) also known as the Rockwood Score.
c) To deliver Comprehensive Geriatric Assessment (CGA) for those entering care homes to ensure that their needs are met. This enables proactive assessment with a focus on quality of life rather than depending on reactive crisis-driven care.
d) To optimise medications through planned reviews thereby minimising potential harm through adverse effects.
e) To undertake anticipatory care planning in partnership with the person/resident to ensure their wishes around end-of-life care preferences are known and, where appropriate, to reduce unnecessary hospital admissions.
f) To ensure appropriate legislative Adults without Capacity (AWI) paperwork is in place and updated as required.
g) To ensure care and clinical governance processes and learning are embedded as part of a wider multi-disciplinary team.
h) To align GP practices to care homes for better outcomes resulting from stronger working relationships and improved communication between GP and care home teams.

Service Criteria

Definition

For the purposes of this LES, a care home is defined as:

A registered care home for an older person which provides accommodation together with nursing or personal care.

For the purposes of this LES a Planned Proactive Review is defined as:

- A routinely scheduled review led by a clinician with advanced assessment and clinical decision-making skills.
- In advance the care home and practice should agree which individuals will be discussed and reviewed.
- SBAR for use by Care Homes to convey resident information – Appendix 1

Exclusions
Residents admitted to a care home for respite purposes with an expected stay of 14 days or less (=<14) will be excluded from this LES. These respite residents will remain registered and receive GMS care from their permanent practice, unless the care home is out with their registered practice's boundary. If the resident is out with their registered practice boundary then they should be registered, as a temporary resident, with the LES holding practice and receive urgent/unscheduled care (as per GMS regulations pertaining to temporary residents).

Care home residents, whether permanent or temporary, retain their right of choice; and could opt to register with any other practice in which the care home is within the practice boundary.

The Care Home will inform the resident (or power of attorney where applicable) if a different practice provides the Care Home LES and should provide them with the details of what that entails.

Where care home residents choose not to register with the practice delivering the LES, they will receive only GMS care.

<table>
<tr><th>Enhanced service requirement</th></tr>
<tr><td>From 1 August 2025, the practice must:</td></tr>
<tr><td>Confirm to the Primary Care Team the name of the registered care home covered by the practice and name of the responsible lead GP.</td></tr>
<tr><td>Code patients as living in a care home and put in place a process to ensure data is captured for new admissions or patients moving out of the care home.
<table>
<tr><td>Lives in a care home</td><td>13FX.</td></tr>
<tr><td>Care home enhanced services administration</td><td>9kw</td></tr>
<tr><td>Provision of respite care in care home or hospital</td><td>.8GE4</td></tr>
<tr><td>Previously lived in care home</td><td>.13Zo</td></tr>
</table>
(Patients falling under 'exclusions' should be coded 8GE4 for the purposes of this LES)</td></tr>
<tr><td>The Practice delivering the LES should provide the care home information on how to contact the surgery in an urgent or emergency situation in a consistent and timely manner.</td></tr>
<tr><td>Ensure the correct clinical coding and GPIT (Vision/ EMIS) toolbar is used to ensure compliance with the recording and monitoring requirements of the LES.</td></tr>
<tr><td>Each resident should have a minimum of 2 Planned Proactive Reviews per year
<table>
<tr><td>Care home visit for initial patient assessment</td><td>9NFW0</td></tr>
<tr><td>Care home visit for follow-up patient reviews</td><td>9NFW1</td></tr>
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It is recognised that there will be some need for flexibility regarding the frequency of visits based on the size of the care home and the needs of the residents. It is expected that the Practice will contact the care home on a weekly, planned basis and provide, at a minimum, one onsite visit per month. Practices will record activity through Vision/EMIS templates/toolbar.
Measure frailty for all registered care home patients using the CFS
Ensure CGA has been completed for each new resident within 2 weeks of admission (noting exclusions above)
Work with primary care pharmacy teams to develop a plan for them to complete structured medication reviews with all existing care home patients at six monthly and annual reviews. This will form part of the holistic CGA.
A medication review should also be completed following discharge from a hospital admission
To ensure appropriate legislative Adults without Capacity (AWI) paperwork is in place and updated as required. This should be recorded electronically on the practice clinical system and a copy provided to the care home for their records
Work with the care home manager to develop a plan to ensure that ALL existing residents & families are offered an opportunity to develop an Anticipatory Care Plan (ACP). The ACP should be reviewed at each Planned Proactive Review i.e. minimum of twice a year; or earlier if appropriate. This should be recorded electronically on the practice clinical system and a copy provided to the care home for their records
Arrangements for Confirmation of Death, by registered Healthcare Professionals, will follow current guidance; and processes and arrangements for issuing the Medical Certificate of Cause of Death (MCCD) should be agreed between the care home and practice.
Have a system in place to provide care home with electronic patient summary within 14 days of admission and updated copies thereafter to reflect change in medication or medical history.
Nominate a lead clinician to work with care home staff and the wider multidisciplinary team to support activity around quality improvement and care and clinical governance. Areas of focus could include: • rates of fracture or reported falls • number of unplanned attendances at Emergency Departments • number of unplanned admissions to Secondary Care • number of people dying in their preferred place

• number of Out of Hours contacts or Scottish Ambulance Service call outs
Practices will respond to any possible outbreaks of infectious disease in care homes as per their contractual GMS requirements. Anything over and above that remains under the statutory remit of the Health Protection Team as per the Public Health Act 2008.

Comprehensive Geriatric Assessment

This guide sets out the Principles of CGA in Primary Care.
CGA Toolkit for Primary Care Practitioners.pdf

A template for recording is within Appendix 3.

The Anticipatory Care Plan
Practices should use KIS and ePCS within GPIT to collate ACP information. A standardised form is also provided to collate ACP information. This should include details of anticipatory prescribing in place, treatment escalation plans and resuscitation status. ACP form Appendix 2
When the KIS / ePCS / ACP records are updated, these must be printed and shared with the Care Home for updating their patient records.

Training and Education

The following training resources are available:

elearning | British Geriatrics Society

Frailty Hub | British Geriatrics Society

Frailty resources - Frailty learning system

Useful Links

healthcare-framework-adults-living-care-homes-health-care-home.pdf (www.gov.scot)

Anticipatory care planning and future care planning

https://www.gov.scot/publications/health-care-home-healthcare-framework-adults-living-care-homes-annual-progress-report-september-2023/pages/7/

Resources to support change ideas | Right Decisions

Recording Information

The following read codes will be used for monitoring and payment purposes:

Read code	**Screen description**	**Read code description**	**When to be used**
13FX.		Lives in a care home	All patients currently residing in a registered care home / New registered patients / existing patient's moving into a registered care home **- claim**
9kw..		Care home enhanced service admin	Care home enhanced services administration for purposes of claim All patients currently residing in a registered care home / New registered patients / existing patient's moving into a registered care home **- claim**
.8GE4		Respite care	All patients who are registered with the aligned practice for a specific period under respite provision or circumstances for fifteen or more days
9NFW0		Care home visit for initial patient assessment	New registered patients / existing patient's moving into a registered care home **- claim**
9NFW1		Care home visit for follow-up patient reviews	All care home registered patients when applicable. Code required at least twice within previous 12 months on basis of two planned proactive reviews annually **- claim**
6AK..		Care home visit for annual patient review	All care home registered patients when applicable
.8O24	Weekly care home ward round	Provision of continuing care in nursing home	Patients coded following weekly care home contact [Weekly care home contact READ]
38DW.		Rockwood clinical frailty scale	All care home registered patients and when score changes
1R1..		Resus status	All care home registered patients if applicable
8BIH		Medication review done by GP	All care home registered patients when applicable
8BIy		Medication review done by nurse	All care home registered patients when applicable
8BIC		Medication review done by pharmacist	All care home registered patients when applicable
8CB		Anticipatory Care plan in place	All care home registered patients if applicable
8CMG.		Review of anticipatory care plan	All care home registered patients if applicable
1R10		DNAR	All care home registered patients if applicable

9e02.		GP Notification to primary care OOHs	All care home registered patients if applicable
.13Zo		Previously lived in care home	All patients no longer living in care home or having deregistered with the practice aligned to care home. Also used in circumstances of patients being admitted to Intermediate care beds covered by separate contract **– cease claim**

3 QUALITY

The service provided should be GMS plus the LES component outlined in this specification.

4 FINANCE

The rate payable for the contract year is **£537.61** per care home resident. Contractors will record when each care home resident moves into their linked care home. Completion of the initial patient admission criteria and assessment will trigger a payment of ½ the annual fee. Each planned proactive 6 monthly review will trigger a further ½ annual fee. Maximum of one claim per patient within a 6-month period. All contractual criteria and standards are subject to quality assurance / payment verification as detailed in Part 1, Paragraph 5 of the overall contract. The practice will provide evidence in instances of unmet standards. Failing to demonstrate intent will result in recoveries as detailed in Part 1, Paragraph 5.3 of the overall contract.

Coded activity and claims will be monitored and reviewed together with PSD quarterly care home registration data. Practices will be requested to provide addition information in support of claims where claims and registration data do not reconcile.

Payments for care homes which close will cease in the month the care home closes.

5 CONTRACT MONITORING

Specific Requirement
Monitoring of this LES will be done through monthly submission/extraction via the reporting tool managed by NSS (Albasoft) analytics using the appropriate READ codes as defined in the clinical specification.

Contract Review
Quality indicators are as detailed in section 3.0 of the contract. For the Contract period the contract review element of the Annual Review will be on the items covered in Section 2.0

Verification
Ad hoc post payment verification will take place as per 4.2 of the contract agreement.

Appendix 1

Care Home SBAR

Appendix 2

Care Home ACP

Appendix 3

Primary Care Comprehensive Geriatric Assessment (CGA)

Appendix 4

Frailty resources - Frailty learning system
This resource is being migrated to HIS – the link will be updated once the content site has been confirmed.

Appendix 5

Where residents have a clinical need and are in respite for 14 days or less, and the resident is out with the practice boundary of their permanent practice, the practice aligned to the care home will review the resident as a Temporary Resident under the basis of immediately necessary essential services.

Where contracts exist for care provision to specific beds, i.e. Intermediate Care Beds, these residents/beds will be excluded from this enhanced service.

Respite Residents (long-stay >14 days)
Residents admitted to a care home with an expected stay of more than 14 days will be registered with the aligned practice and the aligned practice will assume responsibility for all aspects of patient care. All elements of this service will apply including provision of a summary to the care home within 14 days and completions of ACP, DNA CPR, AWI, and advance care planning as appropriate. The resident/PoA/legally appointed guardian/next of kin will participate in completion of the care planning documentation.

When a respite patient returns to their home, the previous permanent practice (prior to registering with the aligned care home practice) agrees to re-register the patient without exception. This includes patients who would normally have been ‘out with the practice area’. This approach is in the patients interests whilst in respite, ensuring clear lines of clinical responsibility whilst not resulting in distress or concern to patients as to continuation of their previously established patient / GP relationship. In circumstances where the patient’s previous practice and care home aligned practice has the patient’s home address within their agreed boundary, patient choice remains as to which practice they will remain registered/re-register with on leaving respite care.